

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for CPT Code 97799-CP and E1300 for dates of service July 7, 2001 through December 12, 2001.
- b. The request was received on April 16, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on July 9, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on July 12, 2002. The response from the insurance carrier was received in the Division on July 23, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated April 15, 2002 that... “____ reduced payment based on payment exception code **M No MAR** used when the IC is reducing payment from the billed amount for t/s for which TWCC has not set an MAR and code... As there is no MAR for the charges, Dr. ____ relies upon protocols established by the Commission of Accreditation of Rehabilitation Facilities (CARF)... The charges for Chronic Pain Management program have no MAR; therefore Dr. ____ expects his usual and customary of \$180 per unit... The insurance carrier has denied payment for services based on exception code(s) M. The insurance carrier has never notified our office of any other reason(s) for denial, other than the above exception codes. For this reason, we are more than prepared to refute the carrier’s position...”
2. Respondent: The respondent states in the correspondence dated July 19, 2002 that... **“The Texas Medical Fee Guidelines list procedure code 97799 as requiring documentation of procedure and provides for reimbursement at a ‘fair and reasonable rate’.** ____ reimburses these services at a fair and reasonable rate of **\$125 per hour** for an accredited provider and **#100** per hour for an non-CARF accredited facility. According to the fee guidelines, documentation is required for services billed with procedure codes designated as DOP.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on July 9, 2001 and extending through December 12, 2001.
2. The respondent has submitted EOBs showing payment for DME code E1399, TENS unit supplies for dates of service August 13, 2001 and December 12, 2001. The respondent paid \$85.00 for each date of service, which is the maximum allowable amount specified in the Medical Fee Guideline, DME Ground Rules (X)(C); therefore, these dates of service are no longer in dispute.
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
07/09/01 07/13/01 07/25/01 07/26/01 07/27/01	97799-CP (4) 97799-CP (3) 97799-CP (4) 97799-CP (4) 97799-CP (4) Total # of hours: 19	\$740.00 \$555.00 \$740.00 \$740.00 \$740.00 19 hrs. x \$180.00 = \$3,420.00	\$400.00 \$300.00 \$400.00 \$400.00 \$400.00 Total amount paid: \$1,900.00	M M M F F	DOP DOP DOP DOP DOP \$3,420.00 - \$1,900.00 = \$1,520.00	MFG, MGR (II)(G) CPT descriptor TWCC Rule 408.021(a)(1-3)	Requestor has submitted daily treatment notes to support the services rendered as billed for DOS 7/26/01 and 7/27/01. Requestor has also submitted EOB's from other insurance carriers supporting payment of \$180.00 per hour; therefore, reimbursement in the amount of \$1,520.00 is recommended.
Totals		\$3,515.00	\$1,900.00				The Requestor is entitled to reimbursement in the amount of \$1,520.00

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$1,520.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 19th day of December 2002.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf